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ABSTRACT

During 1988 there were 4,929 deaths by suicide among persons 15 to 24 years of age in the United States, making suicide the third leading cause of death in this age group, following accidents and homicide. Adolescent suicide is a particularly toxic form of death for the peers who are left behind. A "survivor of suicide" is defined as someone who is left behind to deal with the psychological distress and daily turmoil in the aftermath of a suicide. Adolescent survivors of suicide suffer in at least three ways: (1) they are grieving for someone who died; (2) they are suffering from a traumatic experience--in fact they are victims of Post Traumatic Stress Disorder; and (3) they are socially obstructed from talking about suicide, thereby impeding healing that comes with normal mourning. The death of an adolescent by suicide presents a unique opportunity for healing and nurturance, particularly within the school setting. Time-limited group postvention with peer survivors of an adolescent suicide is a promising practice for helping survivors to process adequately the anger, guilt, and shame which can dominate their lives. Postvention is that process after a suicide, during which an individual and/or a family works toward emotional and psychological recovery and readjustment to healthy living. It includes the provisions of interventions combining education and treatment to prevent bereavement complications for individuals left behind. (Author/BHK)

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ADOLESCENT SUICIDE POSTVENTION IN SCHOOLS: MANAGING GRIEF OF PEER SURVIVORS

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Abstract

During 1988, there was a total of 4,929 deaths by suicide among persons 15 to 24 years of age, making suicide the third leading cause of death in this age group, behind only accidents and homicide. Adolescent suicide is a particularly toxic form of death for peers who are left behind. A "survivor of suicide" is someone left behind to deal with the psychological distress and daily turmoil in the aftermath of a completed suicide. Adolescent survivors of suicide suffer in at least three ways: (1) they are grieving for someone who died; (2) they are suffering from a traumatic experience -- in fact, they are victims of Post-Traumatic Stress Disorder (PTSD); and (3) they are socially obstructed from talking about the suicide, thereby impeding healing that comes with normal mourning. However, the death of an adolescent by suicide presents a unique opportunity for healing and nurturance, particularly within the school setting. Time-limited group postvention with peer survivors of an adolescent suicide is a promising practice for helping to process adequately the anger, guilt, and shame which dominate their lives.

ADOLESCENT SUICIDE POSTVENTION IN SCHOOLS: MANAGING GRIEF OF PEER SURVIVORS

Healing is a matter of time, but it is sometimes also a matter of opportunity (Hippocrates, 460?-377? B.C.)

Problem Overview

Adolescence is a time of life when ordinary levels of stress are heightened by physical, psychological, emotional, and social changes. Lacking coping mechanisms, adolescents can turn to escapist measures such as drugs, which further distance them from reality, and later lead them to view suicide as the "only way out" (Peters, 1985).

During 1988, there was a total of 4,929 deaths by suicide among persons 15 to 24 years of age (National Center for Health Statistics, 1990). Accordingly, this makes suicide the third leading cause of death in this age group, behind only accidents and homicide. Suicide is the sixth leading cause of death among youth aged 5 to 14 years (National Center for Health Statistics, 1990). Extrapolating from these data, one adolescent (age 15 and above) completes the act of suicide every hour and forty-six minutes. Some experts (Curran, 1987; Capuzzi, 1988; Joffe & Offord, 1990) warn that statistics such as these are not accurate and that the incidence of adolescent suicide completions is seriously underestimated.

Curran (1987) has stated that the actual rates of committed suicide are unknown and in the case of young persons, especially difficult to ascertain. Schrut (1964) estimated that the actual rate of adolescent suicide was 50 percent greater than the official figure; this estimate appears to be generally accepted as reasonable (Frederick, 1971; Mishara, 1982; Weiner, 1970). Haim (1974) states that suicide and attempted suicide are most often concealed in adolescent cases for three major reasons: (a) the family (especially the parents) have stronger motives for concealing the suicidal behavior of an adolescent than have the family or neighbors of an adult, (b) there is fear on the part of those responsible for the adolescent that they may be held morally and legally responsible to some degree for the adolescent's suicidal behavior, and (c) adolescent suicide, unlike suicidal acts of other age groups, offers the adult greater latitude for interpretation and more opportunity for ascribing accidental or nonsuicidal reasons for the act. This latter reason is ostensibly supported empirically in that the suicide of an adolescent is typically of a quality which often gives the appearance of accidental death (e.g., motor vehicle deaths, drug overdoses, eating disorders) (Curran, 1987; Joffe & Offord, 1990; Patros & Shamoo, 1989).

Coping with the Death of a Friend during Adolescence

Given the significance of friends in adolescent lives, it is surprising that there is a paucity of research on adolescent bereavement following the death of a peer, and that only a few reports of recent programs in communities or school systems have dealt with various implications of this problem (Evans, 1982; Gray, 1988; Harper, 1982; Klingman, 1985; McNeil, 1986; Ribar & Berman, 1987; Zinner, 1987; McNeil, Silliman, & Swihart, 1991). The paucity of research is doubling perplexing considering the incidence of violent deaths from accidents, suicide, and homicide that accompany adolescent risk taking. Kliman (1978) stated that children who are friends and classmates of a deceased child are "indirect victims," subject to survivor guilt manifested in physical and psychosomatic illness, or acting-out behaviors, especially anger. Many adolescents who had known a peer who died are affected by the death but are less likely to be seen as bereaved "since the bereavement of the families takes precedence" (Raphael, 1983, p. 146). Peer bereavement in adolescence is a matter of "disenfranchised grief" (Berardo, 1988; Doka, 1986), and adolescents bereaved over a friend's death are "forgotten grievers" (LaGrand, 1985) who are seldom given appropriate attention as they struggle to cope with their loss.

Because adolescence is both statistically and metaphorically a healthy phase of the life span, death during this period is likely to be the result of unnatural, seemingly preventable events (McNeil et al., 1991; Noppe & Noppe, 1991). Nobody expects young people to die. When an adolescent does die, the shock, sadness, and anger at the "waste of life" felt by relatives, friends, and acquaintances are inevitable. Primary causes of death in adolescence, nearly 80% of deaths by some statistics (U.S. Bureau of the Census, 1983), are due to "man-made,"events: accidents, suicide, homicide. Therefore, adolescent death is usually a very unexpected and tragic occurrence that may cast the meaning of death for adolescents in a somewhat peculiar, possibly even romantic, light (Noppe & Noppe, 1991). Such romanticization of death may be reflected by the themes of death and destruction that are found in contemporary rock music (Attig, 1986; Wass, Raup, Cerullo, Martel, Mingione, & Sperring, 1988).

Issues in the death of a friend. Friends help us to define and accept ourselves. Their death creates a loss of our identity and a threat to our self-esteem, and it renders our roles as friend meaningless (Deck & Folta, 1989). The level of intimacy among friends is higher than in many other social relationships. The demand of friendship for mutual trust, openness, self-disclosure, concern for each other's interests, affection, and warmth leads to intense identification among friends. Thus, the death of a friend is a profound loss. Since the identification is so great, the sense of loss of self and the threat to self is very intense (Gordon, 1986). There is both the fear that "it could have been me" and the relief that "it wasn't me." The death of a friend confronts adolescents with their own deaths. The death is seen to violate the ideals of fairness, goodness, and justice (Deck & Folta, 1989).

The death of peers also destroys the social network in which the individual is a member and, since most friendship groups are dyads, the death of one means the demise of the group and hence the absence of a social support system. Because friendship is such a unique type of relationship, with shared feelings, secrets, and self-disclosure, after death these experiences cannot be shared or validated. Even the meaning of social events changes. Many joint activities were in large part enjoyable and pleasurable because they were engaged in with a friend and not because of the intrinsic value of the activity itself (Deck & Folta, 1989).

Interpersonal relationships and developmental tasks during adolescence. Although there has been a great deal of attention paid to the suicide of adolescents in this country recently, what has received relatively little attention is the reaction of the adolescent's friends and acquaintances to suicide. One of the differences between the suicide of an adolescent and that of others is that, typically, the adolescent has lived psychologically as much and as intensely in his peer group as in his family. That is, adolescent suicides leave behind *two* sets of intensely affected survivors: their families and their friends. Interpersonal relationship difficulties diminish the availability of otherwise supportive resources, and psychological disturbances, depression, and other emotional stressors, including the circumstances of earlier attempts, exacerbate emotional distancing and feelings of blame (Lukas & Seiden, 1987).

The death of a significant person, such as a close friend, in the life of an adolescent does change interpersonal relationships. Death changes the social structure of survivors no matter what their age. The necessary alterations in the adolescents' roles and functions come at a time when, because of their age, roles and functions are already ambiguous. A change in social structure may have added significance to adolescents because of their developmental tasks. Those developmental tasks include, but are not limited to, issues of: (a) independence/dependence; (b) peer identification; (c) role models; (d) physical and social self-image; and (e) social skills and bonding. Sensitivity to adolescent engagement with these tasks is the context within which all adolescents live. Death of a significant person strongly affects the ways in which adolescent survivors respond to their developmental tasks (Calvin & Smith, 1986).

A Special Case: Peer Survivors of an Adolescent Suicide

Definition. Any discussion of this topic must begin with the designation that a survivor of suicide is someone left behind to deal with the psychological distress and daily turmoil in the aftermath of a completed suicide (Carter & Brooks, 1991b). In a recent nationwide survey conducted by the Gallup Organization (1991) among 1,152 adolescents ages 13 to 19, 60% (691) of the adolescents surveyed said they knew a peer who attempted suicide. Of those adolescents who knew a peer who attempted suicide, over one-fourth (26% or 15% of total) said the peer was successful who succeeded in taking his or her own life.

Distinctive psychosocial sequelae of survivors of a death by suicide. Death, especially a suicide, shakes the very foundation of a youth's being. For the adolescent, who views the self as indestructible, the death of a peer challenges his or her coping resiliency (Patros & Shamoo, 1989). We must recognize that the difficulties a suicide death poses for adolescents extend far beyond the short-term stress of the immediate confrontation with death. Death by suicide adds the exacerbating factors of (a) inadequate or inaccurate information, (b) stigmatization with its emotional distancing from potentially supportive individuals (e.g., friends, family members), and (c) seemingly unacceptable feelings of guilt and anger that complicate the already painful experience of sudden and absolute loss (Carter & Brooks, 1991b).

Suicide survivors suffer in at least three ways. First, because they are grieving for someone who died. Second, because they are suffering from a traumatic experience -- in fact, they are victims of Post-Traumatic Stress Disorder (PTSD) (American Psychiatric Association, 1987; Carter & Brooks, 1991b; Leenaars & Wenckstern, 1991). Third, because people do not talk about suicide -- the silence that surrounds it obstructs the healing that comes with normal mourning (Lukas & Seiden, 1987; Leenaars & Wenckstern, 1991). A death involving a student peer also involves complications: The student may (a) realize that death does not discriminate on the basis of age, (b) believe that he or she "should have done more" in a suicidal situation, or (c) feel that now (with the death of his or her friend) there is no one to talk to or rely on (Floerchinger, 1991).

Adolescent suicide is a particularly toxic form of death for peers who are left behind. Death by suicide presents a sudden loss for which the adolescent could not have been prepared (Carter & Brooks, 1991b). It is often difficult for peers both to cope with the death and to place the death in the proper emotional perspective (Bernhardt & Praeger, 1983a; Bernhardt & Praeger, 1983b; Valente, Saunders, & Street, 1986). The act of suicide and its implications leave emotional scars on the survivors (Bernhardt & Praeger, 1983a; Johnson & Maile, 1987). It is a self-administered, separate and distinct cause of death which cannot be compared to any other crisis.

The stigma and proscription that exist regarding suicide serve to intensify the survivors' feelings of blame, self-doubt, confusion, shame, resentment, and guilt (Bernhardt & Praeger, 1983a; Garfinkel, Crosby, Herbert, Matus, Pfeifer, & Sheras, 1988). Normal avenues of grief support and facilitation from family, friends, and the community are often severed in a suicide death (Bernhardt & Praeger, 1983a; 1983b). It has been suggested that the survivors of suicide death feel that they are living a stigmatized life, and are no longer able to be open with their feelings (Cain & Fast, 1966; Noyes, 1968; Solomon, 1982). Edwin Shneidman, considered to be the father of the suicide prevention movement in the United States, has said,

> I believe that the person who commits suicide puts his psychological skeletons in the survivor's emotional closet---he sentences the survivors to deal with many negative feelings, and, more, to become obsessed with thoughts regarding their own actual or possible role in having precipitated the suicidal act or having failed to abort it. It can be a heavy load (Cain, 1972, p. x).

Bereavement in adolescents following the suicide of a peer. Grieving is the process of separating oneself from losses for survival, to effect necessary changes in life, and to foster new attachments and commitments (Floerchinger, 1991). Bereavement, which includes grief, is the total response over time to a death and is a slow process of recognizing that a beloved person has died and of creating some meaning out of the death (Saunders, 1981). Adolescent peers may find themselves in the process of suicide bereavement. They may easily understand and identify with the struggles and events which have led a close friend to take his or her own life. They, too, may feel responsible for not recognizing suicide potential or not sharing observed clues with others (Bernhardt & Praeger, 1983a). Suicide survivors typically experience fear, rage, guilt and relentless depression (Bernhardt & Praeger, 1983b; Heller, 1985; Worden, 1982). They suffer from the message, conveyed by the death, that the survivor was not good enough to stick around for (Garfinkel et al., 1988). They feel guilty about not having prevented the suicide, or about being angry at the dead person for "deserting"them (Worden, 1982). Unexpressed and unfacilitated, feelings like these fester (Guerriero, 1983; Peters, 1985; Valente & Saunders, 1987). This type of bereavement is associated with a prolonged stress response in many individuals (Gleser, Green, & Wignet, 1981; Wilson, Smith, & Johnson, 1985; Leenaars & Wenckstern, 1991). Unresolved bereavement may lead to ongoing mental health problems such as substance abuse, deviant identity, accidents, psychosomatic illness, and school or career failure (Richman, 1986).

Bereavement produces intense and enduring emotional distress that outsiders seldom appreciate (Balk, 1981; Osterweis, Solomon, & Green, 1984; Silver & Wortman, 1980). Effects of bereavement may affect many areas of an adolescent's life, for instance, self-concept and identity formation, interpersonal relations, school work, family involvement, and overall psychological well-being (Balk, 1991). Adolescent bereavement presents an extremely serious life crisis at a time when development is marked by significant physical, cognitive, moral, interpersonal, and psychosocial transitions. Bereavement can impair successful completion of developmental tasks and present obstacles to what otherwise might have been normal transitions to young adulthood (Balk, 1991).

A traumatic event such as the suicide of a peer can distress adolescents, affecting academic performance and social behaviors, as well as emotional development. In most cases, survivors will have little time for anticipatory grief (Rando, 1984), and may identify depression, anger, and guilt as prominent factors in their bereavement (Raphael, 1983). Grief-related stresses are likely to influence the social systems of adolescents: schools, clubs, athletic teams, church groups, and family units (McNeil et al., 1991). Students together may exhibit responses ranging from focused energy/anger, evident in the spirit of "winning one for the Gipper," to lethargy and depression, in which grieving peers serve as grim reminder's of one's own sense of loss (Wortman & Lehman, 1985).

Survivors experience many feelings that may prolong their grief. Guilt is difficult to avoid when there is no external cause to account for the death (e.g., disease, accident, etc.) (Bernhardt & Praeger, 1983a). Sustained hostility and rage at the suicide and what it has done to the survivors is common (Bernhardt & Praeger, 1983a; Worden, 1982). A sense of release from the pressures of dealing with a suicidal person are typical as well; this release often triggers further cycles of guilt and anger (Bernhardt & Praeger, 1983a; O'Connor, 1984). Estrangement from family and friends is typical because of the threatening nature of the death (Bernhardt & Praeger, 1983a, 1983b). Feelings of loss and emptiness and a sense of disbelief that this could happen are often followed by bouts of self-doubt and recrimination (Bernhardt & Praeger, 1983a; Heller, 1985). Finally, a prolonged period of self-questioning ensues: Why did it happen? Was I to blame? Did I cause it? What could I have done differently? If only I (we) had done this or that, would it have helped? All of these questions contribute to a state of prolonged affective turmoil and a ragged process of grieving (Bernhardt & Praeger, 1983a, 1983b; Valente, Saunders, & Street, 1986).

Proximal and distal outcomes in the aftermath of suicide. Identifying the proximal and distal outcomes in the aftermath of suicide provides one way of understanding the overlapping symptom constellations (Pynoos, 1988; Carter & Brooks, 1991b). As illustrated in Figure 1, a suicide survivor (and worse, a direct witness of suicide) experiences: (a) grief at the loss; (b) worry about someone else committing suicide; (c) reminders of previous loss experiences; (d) overwhelming feelings of loss and hopelessness; and (e) identification with the deceased. All of these experiences lead, respectively, to post-traumatic stress disorder (PTSD), normal bereavement, incomplete bereavement, separation anxiety, exacerbation or renewal of pre-existing symptoms, loss of self-esteem, and depression and suicidal behavior. Rarely, however are these occurrences evident in any pure or isolated form. Rather, suicide survivors are prone to many of these outcomes simultaneously, since grief, depression, PTSD, and suicide are behavioral categories that, despite any theoretical separations, overlap in reality (Carter & Brooks, 1991b). The juxtaposition of symptoms from these three categorizations of grief and trauma reactions show that suicide survivorship includes all the components of normal bereavement, plus the added factors specific to the aftermath of suicide (see Figure 2).

The concept of time and the bereavement process. Each social system's and individual's grieving and coping patterns are unique. Unfortunately, society's expectations of the time necessary to accomplish the work of grieving (usually one year or less) contrast sharply with the research evidence (see Parkes, 1972; Worden, 1982; Parkes & Weiss, 1983). Balk (1981), Worden (1982), Raphael (1983), Rosenblatt (1983), and Rando (1984), among others, have reported that the physiological and psychological effects of profound loss on survivors of all ages may continue in varying intensity for many years. In this light, one can see why mutual-help groups are invaluable since they offer a supportive forum for not only self-exploration and catharsis, but for validating and "normalizing"one's experiences over time (Klass, 1985). Bugen (1979) proposed that the extent and duration of grief reactions probably depend on the centrality of the relationship to the deceased person, as well as on the perceived preventability of the death. In addition, the time since death plays a prominent role in the delineation of appropriate thoughts, feelings, and behaviors. Consider, "It's been four months; I *should* be back to my old self again," or "I *should* be able to concentrate on my school work by now." Kastenbaum (1981) has commented that we are impatient with the bereaved and, seemingly perplexed by the irrationality of grief, we coerce them to quickly "return to normal," at least superficially.

With respect to time, societal pressures to curtail grief expressions emanate from the assumption that "time heals." This is simply not true. In working with the bereaved, it is important to stress that "it is not the time you have to use, but how you use the time you have." Simply noting the time since a death has occurred says nothing about *how* this time was used. Factors associated with delayed or chronic grief reactions include: a highly dependent relationship with the deceased; great ambivalence toward the deceased; the survivor's tendency to avoid stress or conflict; current; multiple, and uncontrollable life stressors; and the lack of a supportive friendship network (Fleming & Adolph, 1986).

The field of anthropology contributes important insight in this regard. Campbell and McMahon (1985) outline the differences between time *Chronos* and time *Kairos*. Time *Chronos* describes a continuum of past, present, and future; it the experience of time measured by clocks and calendars; time measured chronologically. Time *Kairos* refers to "the time within which personal life moves forward" (Campbell & McMahon, 1985, p.84); time *Kairos* is not measured by temporal means but is movement we experience as a result of moments of awakening or realization; refers to a deepening process that results from our paying attention to the present moment, a process through which we are "drawn *inside* the movement of [our] own story" (Campbell & McMahon, 1985, p. 85).

As adolescents experience the full grieving process, time *Chronos* is valuable only in that it gives them a span within which to experience time *Kairos*. The passing of days and weeks and months does not within itself bring resolution to their conflict. Each adolescent has, to use a word favored by the anthropologists, his or her own "entelechy," his or her own "immanent force controlling and directing development" (Turner & Turner, 1978, p. 25). Therefore, the calendar time it takes adolescents to finish the work of their grieving depends completely on time *Kairos* (which can only move forward through our choices) and on their own "entelechy" (Neeld, 1990).

Another expectation involving time is reflected in the frequently heard expression, "when will I get over this?" This reality is "you *never* completely 'get over' the death of a loved one, rather, you learn to live with it." Certainly the acute phase of grief begins to subside, and the pain becomes less intense and more intermittent, with increasingly longer periods of peacefulness intervening. However, incidents such as hearing a favorite song or thinking you have seen the deceased in a crowd may precipitate a grief response of surprising intensity (Fleming & Adolph, 1986).

Some caveats about "normal"versus "deviant"grieving. With regard to what is considered "normal"versus "deviant"grieving, Wortman and Silver (1989) reviewed the research evidence which supports several assumptions reflecting beliefs concerning the grieving process. Specifically, they examined the theoretical and clinical assumptions that: (a) distress or depression in inevitable following loss; (b) distress is necessary, and that failure to experience it is indicative of pathology; (c) it is necessary to "work through" or process a loss; and (d) recovery and resolution are to be expected following a loss. They concluded that these assumptions are not supported by available clinical work on the topic; in fact, in some cases, they are contradicted. Further, they maintain that "a complex mixture of biased input and interpretation of data by outsiders, their own personal needs, as well as limited opportunity for open communication between parties, has lead to a perpetuation of unrealistic assumptions about the normal process of coping with loss. In addition, unrealistic assumptions held by health care professionals and the social network may also unnecessarily exacerbate feelings of distress among those who encounter loss, and lead to a self-perception that their own responses are inappropriate and abnormal under the circumstances" (p. 355). Zisook and Shuchter (1986) have indicated at the present time "there is no prescription for how to grieve properly...and no research-validated guideposts for what is normal vs. deviant mourning....We are *just beginning* to realize the full range of what may be considered 'normal grieving'" (p. 288, italics added). Recognition of this variability is crucial in order that those who experience loss are treated nonjudgmentally and with the respect, sensitivity, and compassion they deserve (Wortman & Silver, 1989).

Postvention in the Schools with Adolescent Survivors

What is "postvention"? An adolescent's death is not only an ending; it is also a beginning for the surviving peers left behind. Postvention began as "those appropriate and helpful acts that come after the dire event itself" (Shneidman, 1981, p. 349). Postvention is (a) that process after a suicide during which an individual and/or a family works toward emotional and psychological recovery and readjustment to healthy living (Hatton, 1977) and (b) the provision of interventions combining education and treatment to prevent bereavement complications for individuals, families, and groups left behind (Webb, 1986; Carter, in press). If we assume a realistically low average of five family members and five peers who are significantly affected by the loss of a significant other for each adolescent suicide death, then the United States includes 70,000 survivors of adolescent suicide each year who are involved in the difficult process of "postvention." It is important to keep in mind that this is a conservative estimate and spans only a one-year period.

Crisis or opportunity? The death of an adolescent by suicide presents a unique opportunity for healing and nurturance (Carter & Brooks, 1991a). With timely, appropriate assistance, individuals can be helped through trauma (e.g., a suicide, a disaster). An opportunity for change and growth is intrinsically presented by any crisis (Carter & Brooks, 1990). This is not a novel concept. This ancient wisdom is directly evident in Chinese graphology, wherein the character signifying "change"is incorporated into the ideogram for "crisis"and the ideogram for "opportunity"(see Figure 3). Perhaps the words of Dr. James O. Wells (1982)--one of the psychologists who addressed the Challenge disaster in Christa McAuliffe's home school--may provide hope: "The crisis of disaster can be an opportunity to learn from experience and to form the relationships which may be tapped in future crises."

Why postvention in schools? At least three considerations justify the school's involvement in postvention activities for peer survivors after the suicide of an adolescent: (1) schools have the responsibility of helping adolescents develop into productive citizens who can contribute positively to society; (2) schools have the responsibility to identify and attempt to identify and attempt to resolve problems that interfere with the educational process; and (3) schools have the opportunity and resources to identify and offer assistance to at-risk adolescents (Smith & Garza, 1989). An individualized approach is as necessary for each specific school where postvention is instituted as it is for each person needing support in the aftermath of suicide or parasuicide. Accordingly, postvention for young people is an important arena for cooperation between the counseling and educational professionals on site at the schools and the mental health professionals who are specially trained and experienced in this procedure (Carter & Brooks, 1990).

School postvention programs represent an "organized response of a caring, humanistic institution in addressing the traumatic loss of a student in such a way that the emotional needs of those remaining are dealt with effectively." (Hoff, 1984, p. 387). They are designed specifically to address the traumatic loss of a student by forestalling possible psychological damage within our posttraumatic stress disorder (PTSD) framework and to facilitate the grief process (Wenckstern & Leenaars, 1991). A major concern and thrust of such programs is addressing the contagion or "copycat"effect (Lifton, 1969) by preventing suicide role modeling (Lamartine-Anderson & Sattem, 1986).

Wenckstern and Leenaars (1991) have summarized eloquently some principles of postvention which they derived from Shneidman (1981) but which they have modified liberally for application within a school setting:

1. In working with survivor victims of suicide, it is best to begin as soon as possible after the tragedy, within the first 24 hours if that can be managed with children at the school;

2. Resistance may be met from the survivors; some--but not all--are either willing or eager to have the opportunity to talk to professionally oriented persons;

3. Negative emotions about the decedent (the deceased person) or about the death itself--irritation, anger, envy, shame, guilt, and so on--need to be explored, but not at the very beginning. Timing is so important;

4. The postvener should play the important role of reality tester. He or she is not so much the echo of conscience as "the quiet voice of reason";

5. Referral to community services may be crucial in some cases. One should be constantly alert for possible decline in physical health and in overall mental well-being;

6. Needless to say, Pollyannaish optimism, or banal platitudes, should be avoided;

7. Trauma work takes awhile--from several months to the end of life, but certainly more than 3 weeks or 6 sessions; and

8. A comprehensive program of health care on the part of a benign and enlightened community should include preventive, interventive, and postventive elements.

Postvention programs need to be developed before they are actually needed. When an adolescent suicide occurs, the resulting effects spread throughout the lives of his or her peers like ripples spreading from a stone thrown into water (Johnson & Maile, 1987). As the startling statistics presented earlier indicate, suicide is not something that only happens in someone else's school district. When an adolescent has actually committed suicide, it becomes necessary, within the context of a school setting, to assess the impact of such an event on the system (Capuzzi, 1988).

Postvention programs in the schools should incorporate both an immediate crisis response and a long-term follow-up plan. The school should be sensitive to the surviving adolescents' needs, from the mildly upset to the severely depressed. Programs should involve students, teachers, administrators, counselors, parents, and community health resources. Davidson (1990) states that adequate postvention at the school level should include (a) appropriate information-sharing and discussion with relevant groups of students within the school, (b) screening of individuals at high risk, and (c) triage of carefully identified students into appropriate treatment.

Immediate Response

Time is probably the most important element for competent postvention (Carter & Brooks, 1991a). Full processing of the inevitable feelings of anger, guilt and despair involves varying amounts of time for different people. Another essential component is tolerance for these emotions. Many people find it so difficult to accept anger, guilt and despair that denial prevents adequate processing of the pain experienced after suicide or parasuicide. Obviously denial is involved when an action is labelled accidental rather than suicidal, but denial is also involved when professionals or friends attempt to protect survivors by curtailing emotional reactions or, conversely, by trying to hasten emotional resolution (Carter, in press).

In most cases, postvention should be recognized as "pursuant." As with any crisis intervention, since support services are generally not sought by the individuals directly involved in the crisis, suicide crisis workers in the schools must pursue adolescent survivors in order to initiate postvention activities (Carter & Brooks, 1990). Valente and Sellers (1986) have outlined several reasons why adolescents do not seek help: (a) Some adolescents do not know about available resources; (b) Some adolescents have not mastered the ability to put feelings into words; (c) Some adolescents fear that needing help may signal weakness; (d) Some adolescents wish to protect their families and themselves from their confusion and inner turmoil by reporting and trying to believe, "I'm fine." They try to act like an adult and cope alone with the severe physical and emotional responses following a suicide.

The trauma of suicide may make it difficult for survivors to reach out for support as they become overwhelmed by feelings of abandonment, rejection, social isolation, and confusion. Yet, some survivors may not be able to cope with the meaning of suicide, feelings of anger or blame, or damage to self-esteem when they are alone. When feelings are blocked, suicide is considered, or life remains empty and joyless, counseling can provide a safe place for sharing grief, confusion, anger, or fear. Schuyler (1973) suggests that counseling must: (a) provide a nonrejecting atmosphere to encourage feelings and to support grief and mourning, (b) help the adolescent expand social support and build relationships by reaching out for comfort, and (c) help individual adolescents respect their own styles of grief (males and females may tend to express grief differently). For some survivors of suicide, individual therapy is most effective because they relate best to one trusted person; for others, a support group of similar survivors facilitated by a therapist knowledgeable in suicide and bereavement is very effective. Still other survivors maintain that they find it most helpful to have fellow survivors lead self-help groups.

Helping adolescents mourn: Facilitative and nonfacilitative statements. Davidowitz and Myrick (1984) analyzed statements from a small sample of "caring" persons and their impact on the survivors. They found that statements could be placed along a continuum encompassing facilitative (showing support and understanding)and nonfacilitative (fostering alienation and hurt) categories. Some examples they give are:

Facilitative	**Nonfacilitative**
Come with us now.	He (God) had a purpose.
You're being very strong.	I know how you feel.
It's okay to be angry at God.	Time makes it easier.
It must be hard to accept.	You have to keep on going.
That must be very painful for you.	You're not the only one who suffers.
Tell me how you're feeling.	That's over now, let's not deal with it.
How can I be of help?	The living must go on.
Go ahead and grieve.	She has led a full life.

Somewhat surprisingly, they found that 80 percent of all the responses made by "caring persons" could be categorized as nonhelpful and low-facilitative in nature. The analysis revealed that most people are, in fact, not very helpful in what they say to the bereaved. These results led them to suggest that people learn to focus on high facilitative responses as a means of providing supportive encounters.

> When caring people learn to make more facilitative responses they are helping to build a bridge to the bereaved and enabling them to gently cross from the depths of despair to the shores of understanding, acceptance, and personal growth. (Davidowitz & Myrick, 1984, p. 41)

Approaches to suicide postvention therapy. Three approaches to suicide postvention therapy have been elaborated, all from the crisis intervention model (Lindemann, 1944). Short-term postvention of one to three sessions provides didactic and evaluative consultations that enable assessment of suicide aftermath symptoms in individuals identified as likely to be at-risk, and provides referral for therapy needed beyond the postvention (Leenaars, 1985; Leenaars & Wenckstern, 1986; Zinner, 1986). Intensive therapy of a few months to several years is the long-term approach to postvention, where the full gamut of ramifications from the suicide are addressed for the individual. While such long-term postvention is likely to be warranted by the continued aftermath of trauma (Shneidman, 1981), more easily accepted is the intermediate protocol of 10 to 16 weekly sessions. This format is called "convergent postvention" as it "converges"between the two extremes (Baldwin, 1980; Yalom, cited in Farberow, 1976).

Special treatment issues with adolescents. Thompson (1990) has delineated some special issues to consider when intervening with adolescents after the death of a peer by suicide. They are ---

- Allow regression and dependency
- Realize adolescents' lack of life experience in handling trauma
- Allow expression of feelings such as sorrow, hostility, and guilt
- Encourage discussion
- Allow for fluctuations in maturity level
- Watch for emergence of unfinished business or unresolved conflicts of the past
- Answer questions and provide factual information
- Correct distortions
- Avoid power struggles
- Focus on strengths and constructive adaptive behaviors
- Address unconscious as well as conscious guilt
- Identify and resolve adolescents' sense of powerlessness

Grief work: An integral component of postvention. Although postvention work is not merely grief counseling (Wenckstern & Leenaars, 1991), postvention in schools requires that the professionals involved have expertise in grief counseling and knowledge of the dangerous effects that a suicide can have on survivors (Smith, 1991). Additionally, given the inevitable intensity of postvention work, Carter and Brooks (1991b) have stated that postvention works more efficiently with two (co-) therapists/counselors rather than a single postventionist. Two professionals working in tandem create an not only an atmosphere of control in an environment laden and swirling with emotions, but also provide the opportunity for enhanced professional perspective and sharing of the actual therapeutic burden as the postvention process evolves.

Example of a group agenda for "convergent postvention" with peer survivors of an adolescent's suicide. The following agenda for a time-limited group "convergent postvention" was adapted from a model developed by Carter (in press):

Problem 1: As a close friend of an adolescent who committed suicide, (participant's name) is at-risk for self-destructive behavior.

Goal 1: To engage in no self-destructive behavior.

Problem 2: This suicide raises many feelings regarding losses and separations.

Goal 2: To talk about feelings at each session in order to experience and accept the full range of affect.

Process: Peer group postvention with counselor's/therapist's name; 45 minute weekly sessions for 3 months (12 sessions).

Modality: The postvention group will explore and address the many sources of separation and loss inevitably part of the human experience. Topics will include the suicide itself, acknowledgement that each person grieves in a unique way, on-going changes in friendships and family relationships, and present and future plans. In this way, the friends of the deceased adolescent will learn new adaptive relationship strategies.

Target Date: (Date twelve weeks from first session.)

It has been stated that postvention efforts can do more harm than good if they become disguised and misguided attempts to protect survivors from the painful emotions they must process if they are truly to survive (Carter & Brooks, 1991a; Carter, in press). The difference between facilitating the psychological process and interfering with that process can be a very fine line. The impact of a given intervention can even vary in appropriateness depending on the particular person being helped. Postvention, therefore, must be a "clinical,"i.e., an individual, intervention, even within the context of a didactic approach to suicide prevention (Carter & Brooks, 1990). It is essential to maintain a focus on the survivor as an individual and provide opportunities for emotions to evolve in a manner appropriately (i.e., empathetically) responsive to that individual. For example, many survivors have responded well to the idea that their feelings of guilt represent positive caring for others more than any real culpability. It should be remembered, however, that as useful as this reframing may be for some people, for others it could function as an impediment to processing of the grief and anger which gave rise to the guilt feelings (Carter, in press).

Long-Term Postvention

The emphasis in long-term postvention is not one-to-one psychotherapy; rather, it is on creating a positive environment. An astute principal, through careful planning, may be able to buffer the predictable post-suicide depression. School can provide both a structure of normality and a tremendous resource for healing. The literature on postvention programs suggests that most of the healing process should be directed by mental health professionals. The common view is that the classroom functions primarily as a tool to screen for students in need of intensive therapy. The value of using the classroom to identify students with special needs is obvious. All-to-often, however, the classroom is overlooked as a resource for direct healing.

Use of teachers and other staff in long-term postvention. Both English and art teachers are in a very strong position to provide support. Johnson and Maile (1987) note that "youth will frequently display feelings through drawing or writing when at the same time they might feel very reluctant to speak of them openly" (p. 216-217). Expressions of grief, fear or confusion through art or writing may have a cathartic effect. The intent is not to focus on the suicide, but to provide the student with a vehicle for communicating intense and confusing emotions (Poland, 1989; Smith, 1985). Observed strong feelings and heavy emotions are worthy of at least some attention and further explanation (Johnson & Maile, 1987).

Johnson and Maile (1987) suggest that the sensitive librarian might be an excellent source of information. Literature on stress, coping and communication skills could be highlighted in a media display. A librarian that is sensitive to students' interests and hobbies can provide a supportive environment. Likewise, physical education teachers are in a position to offer direct interventions with stress reduction classes. Weekly or bi-weekly sessions of stress reduction exercises may be beneficial to both students and staff. The immediate crisis postvention plan is critical. A less intense follow-up program is a necessary complement to the initial response. An extended postvention, up to two years, may identify those students who are not coping, facilitate the healing process and, as Johnson and Maile (1987) suggest, serve as a prevention plan for younger students.

In the weeks immediately following the suicide, students' performance in school may be at the mercy of their emotions. Schools need to be compassionate with survivors regarding academic performance (Guetzloe, 1989). Educators sometimes do not understand how traumatic it is to survive a suicide and may expect too much too quickly with regard to academic performance. Poor performance should neither be judged harshly nor ignored.

If the bereaved adolescent is unable to carry out the usual living activities after a period of time, help from outside the school may be needed (Heller, 1985). Solanto (1984) has offered the following general considerations which should be evaluated in order to determine the need for a mental health referral:

1. It should be expected that some students will cry. Students who have been unable to control their crying by the end of the class period are obvious choices for referral;

2. At the other end of the continuum are students who are showing no visible emotion. "Expected reaction" is a function of the degree of closeness between the victim and the student. In the cases where it is known that a student was close to the victim yet is showing no reaction, a referral is recommended. This category is the most difficult to assess. Many students who were not close to the victim will feel very little. Also, a numb, dumbfounded response is a common response to a tragedy such as suicide. Finding the emotionally overcontrolled student among this group will depend primarily on a teacher's knowledge of social relationships;

3. Anger as well as grief is a normal response to suicide. However, if a classroom is responding predominantly to grieving, then an angry student may feel compelled to remain silent. This student would make a good candidate for referral.

At the same time as the school works towards being of assistance to the individual, it should be noted that in no sense does the school have either the right or responsibility to act as a surrogate professional therapist. Some individuals will need specialized outside help, instead. Knowing that some problems are too intense and too complex for the school to handle and being able to offer assistance in finding appropriate help is in itself a supportive and healthy contribution to the individual's mental health (Johnson & Maile, 1987). The possible physical and mental impact of an adolescent's suicide on his or her surviving peers needs to be recognized and the specific affective needs of this group need to be addressed, at least partially, in the school setting (Johnson & Maile, 1987; Valente & Saunders, 1987). School staff can play an important role assuring that the grief which adolescent survivors experience is good grief -- that it helps the surviving peers stay psychologically healthy and that it strengthens their capacity to cope with future losses (Fox, 1989).

Postvention and Contagion

Regarding the possibilities of contagion effects, the postvention process is, in a very real sense, a prevention process as well. Overall, exposure to suicidal behavior increases an adolescent's risk of self-destructive behavior through many avenues, possibly including contagion due to direct contact (Carter, in press). Those adolescents who are particularly vulnerable and without adequate supports or effective means of coping may become dangerously at-risk as they collide with the experience of suicide (Curran, 1987). However, it appears that many people have been so concerned about contagion that they have refused to comment on or acknowledge suicide. In fact, contagion concerns have been highlighted as the major reason why most school systems do not have postvention policies (Lamartine, 1985; Poland, 1989).

When addressing the issue of contagion, it must be stressed that suicidal adolescents do not represent a normal, well-functioning population of adolescents (Crumley, 1982; Curran, 1987; Jacobs, 1971; Weiner, 1970). Wasserman's research (1984) suggests that contagion depends as much on the type of person modeling the suicidal behavior as on the type of person exposed to it. Those adolescents who are particularly vulnerable and without adequate supports or effective means of coping may become dangerously at risk as they collide with the experience of suicide (Curran, 1987). Shafii, Carrigan, Whittinghill, and Derrick (1985) conclude:

> Exposure to suicide or suicidal behavior of relatives and friends appears to be a significant factor in influencing a vulnerable young person to commit suicide. Other factors that contribute to vulnerability are history of antisocial behavior, inhibited personality, frequent use of drugs or alcohol, history of emotional problems in parents or self, and parental absence or physical or emotional abusiveness. (p. 1064)

In sum, there is some evidence for an imitative or contagion effect in adolescent suicide, and schools need to recognize this but not be handicapped by it.

Regarding the notion that suicide is a topic of conversation best left alone, Carter and Brooks (1989) offer the important caveat that "it would be dangerous to generalize concern about contagion into perpetuation on the myth that talking about suicide encourages suicidal activity" (p. 248). Coleman (1987) states, "...on an individual basis, asking someone if he is thinking about killing himself does not put the idea in his head. It usually assures a suicidal individual that you are not afraid to dealt with him [directly and openly about]...what he is already considering" (p. 128). Boggs (1987) notes the survivors' need for an open discussion to gain support, and cautions that a nonsupportive, closed atmosphere may result in students' keeping their suicidal thoughts to themselves and being more likely to follow through on an attempt. Clearly, information about the benefits of openly discussing suicidality is needed to counter the predominantly negative attention on suicide contagion (e.g., the danger of setting an example, the danger of seeming to normalize suicide by acknowledging it as an option, the danger of romanticizing the results of suicidal activity) (Carter, in press).

Summary

Suicide by an adolescent is a psychosocially violent death, primarily because it is unanticipated by others and is unnatural. It is an act of aggression against both the victim and the peer survivors, who must manage a complex set of emotions. For the majority of adolescents exposed to the suicide of a peer, healing will come passively from the environment. However, grieving and recovery require time, support and interaction with sensitive and caring people. The school milieu where adolescents spend many of their waking hours is a crucial site for implementation of a suicide postvention program. The school should be sensitive to the surviving adolescents' needs, from the mildly upset to the severely depressed. Time-limited group postvention with peer survivors of an adolescent suicide is a promising practice for helping to process adequately the anger, guilt, and shame which dominate their lives.

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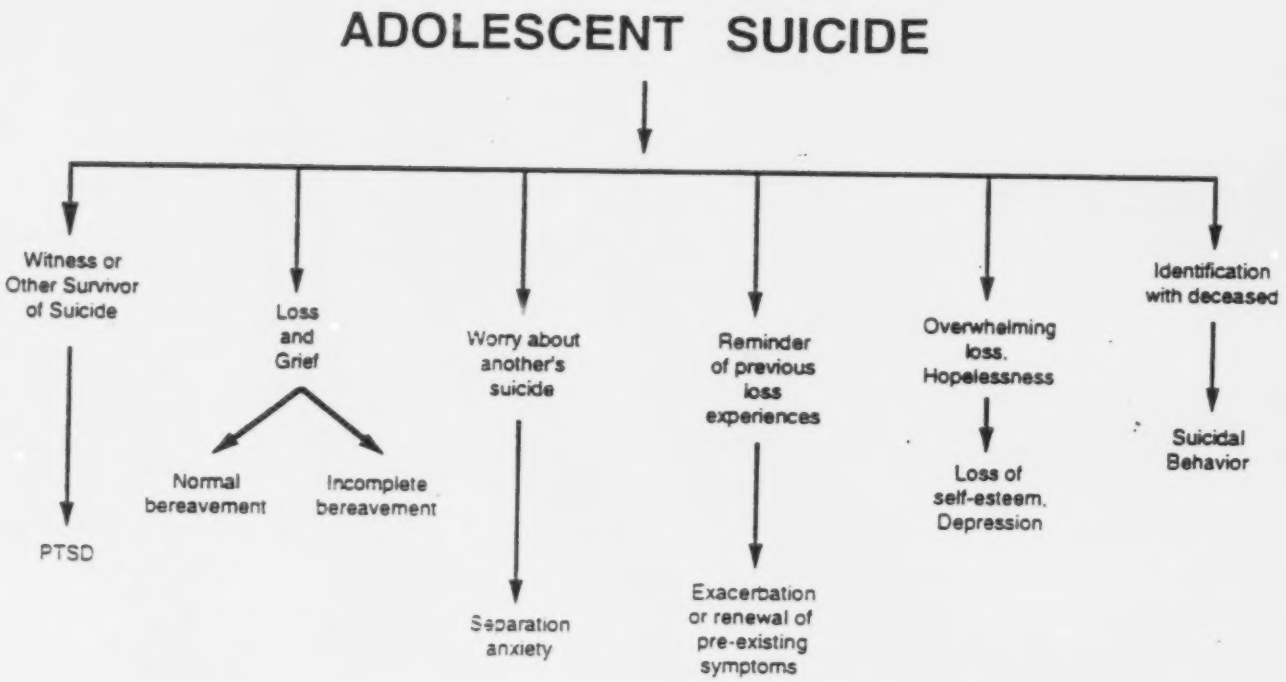

Figure 1. Outcomes of adolescent suicide survivorship.

(Adapted from Pynoos, 1988; Carter & Brooks, 1991b)

FIGURE 2

Symptom Comparison Across Grief, Suicide Survivorship,* and PTSD As Manifested in Children and Adolescents

Normal Grief	Suicide Survivorship	PTSD
Anger		
Agitation		
Crying		
Insomnia		
		Dreams: Repeat the trauma; include death, prophetic dreams
Appetite loss		
Regressed Behaviors		
Irritability		
Shock		
Guilt	Extreme guilt	
Helplessness	Extreme helplessness	
		Extreme terror Extreme panic attacks Extremely cautious Easily overwhelmed
Fatigue		
Separation fears		
Anxiety		
Physical complaints		
		Perceptual distortions Visual distortions
Academic difficulties		
Social withdrawal		
Daydreaming		Excessive daydreaming
	Denial or covering of the suicide	Denial via "screen" memory or cover story
		Repetitive play
Search for meaning	Exaggerated search	
		Search for omens
Inability to concentrate		
Repeated grieving at later developmental levels		
Abandonment fears		
Distrust of relationship permanence		Relationships seen as fragile
Depression	Chronic depression Stigma Contagion Dysfunctional communication	
	Blame of self and others	
		Extreme shame
	Breach of trust	Profound distrust
	Personality disorganization	
		Intrusive thoughts of the trauma
Preoccupation with death	Preoccupation with suicide	Preoccupation with death
Fear of self dying	Obsession with suicide	Fear of self dying
Fear of others' dying	Fear of others' suicide Suicidal behavior	
		Fear of further local disasters Futurelessness: foreshortened view; profound distrust Skewed sense of time
Interference with development	Greater interference with normal development	
Adversary reactions	Includes suicidality	Includes renewed posttraumatic repetitions

*(From Carter & Brooks, 1991b)

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Figure 3

CHANGE

機

CRISIS

危機

OPPORTUNITY

機勢

Ideograms From Chinese Graphology